The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Supported Living Service**

Provider: **Southern HSC Trust**

Date of Inspection: **27 November 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Supported Living Services Southern HSC Trust
Responsible Individual/Responsible Person:	Mr Steve Spoerry
Registered Manager:	Mrs Sarah McCartney
Service Profile – Supported Living Services, is a domiciliary care agency supported living type, providing care and support to eight individuals who live in the Lurgan area. The agency's registered office is located in one of the homes of the service users. Service users have a range of needs including mental health issues, learning disabilities and autism.	

2.0 Inspection summary

An unannounced inspection took place on 27 November 2025, between 11.00 and 4.30 pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards, and to assess progress with the areas for improvement identified during the last care inspection on 2 December 2024.

As a result of this inspection five areas of improvement identified in the previous inspection relating to Safeguarding practices and record keeping, staff training, restrictive practice and staffing arrangements were assessed as having been addressed by the provider. This is discussed in more detail in sections 4.1, 4.2 and 4.3.

This inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. There were no improvements identified as a result of this inspection. Further details of the findings of this inspection are outlined in the main body of the report.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the agency was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning Trust.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires and an electronic survey.

Throughout the inspection process inspectors seek the views of the service users who are in receipt of care and support; their relatives/representatives, care workers and HSC staff. A review/examination of a sample of records is also undertaken to evidence how the agency is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

We approached relatives, staff and HSC professionals to seek their views of visiting and working within Supported Living Service.

Relatives who spoke with the inspector indicated that they were satisfied with the care and support provided to their loved one.

Staff who spoke with the inspector spoke positively about the approachability and support of management and that they felt the service was well- led. Staff said the care provided to service users was safe, effective and compassionate and that staff morale had much improved and that they worked well as a team.

One HSC professional who provided feedback on the service said that they were satisfied with the care delivered to service users from staff and that a good rapport was observed between staff and service users. Another professional who spoke with the inspector said that the service was in a good place now after a difficult period and that service users were notably content with good support noted from staff.

Written responses to the service user questionnaire indicated that service users were satisfied with the care provided by the service. One survey indicated that there were some internal environmental improvements needed. The inspector relayed these comments to the manager to act upon as necessary.

4.0 Inspection findings

4.1 Staff Recruitment, Induction and Training Arrangements

A review of the agency's staff recruitment records confirmed that all pre-employment checks including criminal record checks (AccessNI) were completed and verified before staff members commenced employment and had direct engagement with service users.

Review of a sample of the most recently appointed staff, evidenced that staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care. There was a robust, structured, induction programme which included 'shadowing' of a more experienced staff member. This was reviewed periodically and signed off to ensure competence in carrying out the duties of their job in line with the agency's policies and procedures.

An area for improvement identified at the previous inspection related to staff training and review of this by the manager. The agency maintained an electronic record of all staff training; however a review of this record, evidenced a number of staff required refresher training in several mandatory training areas. The person in charge advised that this was due to a technical issue and has since provided confirmation that staff have either completed these training requirements or are booked on to the next available date. On this basis the area for improvement is deemed to have been addressed by the provider. Staff confirmed that they were provided with opportunities to complete training commensurate with their role.

All staff had been provided with training in relation to medicines management. Competency assessments were undertaken with staff to ensure that they were proficient in administration of medications and these were refreshed annually.

An area for improvement highlighted in the previous inspection related to staffing arrangements. A review of the staff rota noted that it contained information relating to the manager's working arrangements. There were good systems in place to manage staffing and on the day of inspection, there were enough staff on duty to support service users. Staff said there was good teamwork and that they felt well supported in their role. The manager is registered to manage three registered services and the current arrangements were known by staff. On this basis the previous area for improvement was assessed as met.

4.2 What are the systems in place for identifying and addressing risks?

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's adult safeguarding policy and procedures were reflective of the Department of Health's (DoH) regional policy and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). Staff were required to complete adult safeguarding training during induction and every two

years thereafter. Staff who spoke with the inspector had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidences of abuse and the process for reporting concerns in normal business hours and out of hours.

Discussions with the manager established that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting and managing adult safeguarding concerns.

An area for improving identified at the previous inspection related to the management of Adult Safeguarding records. A review of these records confirmed that the agency held a separate record of any Adult Safeguarding concerns raised. The service had also developed and implemented a database for recording accidents/incident and safeguarding concerns that arose. It was positive to note that this was reviewed by the manager on a monthly basis to aid in identifying any trends / patterns and to inform ongoing quality improvement within the service. On this basis the area for improvement was deemed to have been addressed. The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

An area for improvement identified at the previous inspection related to the timely implementation of protection plans in response to adult safeguarding concerns. A review of the management of adult safeguarding concerns evidenced that protection plans had been implemented appropriately. On this basis the area for improvement was deemed to have been met.

The agency's governance arrangements for the management of accidents/incidents were reviewed. The review confirmed that an effective incident/accident reporting policy and system was in place. Staff are required to record any incidents and accidents in a centralised electronic record. A review of a sample of accident/incident records evidenced that these were managed appropriately.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

4.3 Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS) and Restrictive Practice

The Mental Capacity Act (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff who spoke with the Inspector demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the MCA.

Staff had completed appropriate DoLS training appropriate to their job roles. The manager reported that none of the service users were subject to DoLS, however some restrictive practices were in place. An area for improvement identified during the previous inspection related to restrictive practices and how these were recorded. There was a policy in place for the use of restrictive interventions and a restrictive practices register in place which was reviewed regularly and kept up to date. All relevant documentation was available in the service users' care records. On this basis the area for improvement was assessed as met.

4.4 Management of Care Records and Care delivery

Service users' needs were assessed when they were first referred to the agency and before care delivery commenced. Following this, initial assessment care plans were developed to direct staff on how to meet service users' needs and included any advice or recommendations made by other healthcare professionals.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the service users' needs. The service users' care plans contained details about their likes and dislikes and the level of support they may require. The details of care plans were shared and signed by service users and/or their representatives as appropriate. There was also evidence of regular contact with service users and their representatives, in line with the commissioning trust's requirements.

There was a daily handover at the beginning of each shift and staff recorded regular evaluations about the care and support provided on a template. This included information about any changes to the service users' care needs so that staff could assist them as needed accordingly. There was a system in place for recording the management of individual service users' monies in accordance with the guidance.

4.5 Managerial oversight and Governance

There has been no change in the management of the service since the last inspection. Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance. Staff told us that they would have no issue in raising any concerns regarding service users' safety or care practices and that they were confident that the manager or person in charge would address their concerns. There were procedures in place to appraise staff performance.

The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the service in compliance with regulations and standards. A review of the reports of the agency's quality monitoring established that there was engagement with service users, service users' relatives, staff and HSC Trust representatives. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

There was a range of policies available to direct staff in care delivery and support planning based on individual risk assessments. The annual quality report was reviewed and noted to include stakeholder feedback.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

The agency's registration certificate was up to date and displayed appropriately.
There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. No complaints were received since the last inspection.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Sarah McCartney (Manager), as part of the inspection process and can be found in the main body of the report.

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